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Comments on the "Path to Transformation" 1115 Waiver Concept Paper

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The mission of the AIDS Foundation of Chicago (AFC) is to lead the fight against HIV/AIDS and improve the lives of people affected by the epidemic. Founded in 1985 by community activists and physicians, the AIDS Foundation of Chicago is a local and national leader in the fight against HIV/AIDS. We collaborate with community organizations to develop and improve HIV/AIDS services; fund and coordinate prevention, care, and advocacy projects; and champion effective, compassionate HIV/AIDS policy.

HIV infection can be managed as a chronic disease if people with HIV have access to high-quality, culturally-competent medical care and supportive social services. Providing this optimal care leads to long- and short-term cost containment as well as improved quality of life and prognosis for the patient, helping to meet the Triple Aim. There are an estimated 42,500 people living with HIV in Illinois, and about 1,760 people are newly reported as diagnosed with HIV each year in the state.[1] According to the Illinois Department of Healthcare and Family Services, 12,734 people with HIV were on Medicaid in 2011.[2] AFC estimates that, thanks to the Affordable Care Act Medicaid expansion, an additional 11,400 people will become newly enrolled in Medicaid in Illinois by 2017, raising the number of people with HIV on Medicaid to over 24,100.

Today, HIV is unique because while it can be treated as a chronic disease, we cannot forget that it remains a communicable disease. This creates a public health imperative that also serves the taxpayer. Every person with HIV who is successfully treated has a dramatically lower risk of transmitting HIV in the community; in fact, new evidence released by the National Institute of Health (NIH) demonstrates that consistent adherence to HIV medications reduces the chance that HIV will be transmitted by 96%.[3] This shows that access to HIV treatment has

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[1] AFC estimate based on Chung Eui Kim & Fangchao Ma, "Community Viral Load and Social Determinants," Illinois Department of Public Health, presented at Illinois HIV Planning Group Meeting in Collinsville IL on September 14, 2012;

[2] Illinois Department of Healthcare and Family Services, special data request, received 4/30/2013

[3] Cohen, Myron S., et al. *Prevention of HIV-1 Infection with Early Antiretroviral Therapy.* 2011 New England Journal of Medicine 493-505: V365, no 6, http://www.nejm.org/doi/full/10.1056/NEJMoa11052

enormous public health benefits and cost savings. Each HIV case prevented saves a minimum of $380,000 in lifetime treatment costs,[4] much of which will be paid by the state.

We are at a critical juncture for the AIDS epidemic. Over the past 30 years, the federal government invested an estimated $1 billion or more in a specialized safety net for people with HIV in Illinois. This network, created by the Ryan White Care Act and enhanced by the state, provides culturally competent, high-quality care that integrates medical and social services to meet the needs of people with HIV. Although the system is not perfect and is in need of modernization, many in the field believe the Ryan White Program created the original medical home after which all others should be patterned. This critical infrastructure is in jeopardy because people with HIV are about to get what they need most - comprehensive health insurance coverage.

As health reform is implemented, funding for the Ryan White Program will almost certainly decline. The state and federal government faces a choice: to harness and modernize this proven, expert infrastructure to improve care for people with HIV and fill the many gaps in the system, or simply watch it fade away.

AFC strongly believes that the 1115 waiver and the Medicaid delivery system transformation has the potential to improve outcomes for people with HIV, and can do so **only** by leveraging the public health system's investment in HIV infrastructure. Critical strengths of the current system that new networks can build on are:

- A culturally-competent workforce that is knowledgeable about HIV, based in the communities where people with HIV live,
- Integration with programs that address the social determinants of health, such as housing, and
- A robust case management system that ties the health and social services system together.

However, there are many challenges that the current HIV system has been unable to address. For example, an estimated 20% (1 in 5) of people with HIV are undiagnosed, meaning they have HIV but don't know it.[5] Over half of people diagnosed with HIV are not receiving any routine HIV medical care,[6] either because they were never liked to HIV care when diagnosed or they dropped out of care. Far too many people with HIV are diagnosed late in the course of the disease, requiring medical treatment that is nearly three times as expensive as early treatment ($36,352 per year for someone who has advanced HIV compared to $13,885 per year for someone with HIV who is healthy[7]).

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[4] *HIV Cost Effectiveness,* U.S. Centers for Disease Control and Prevention, January 5, 2012. Accessed 6/19/13 from www.cdc.gov/hiv/topics/preventionprograms/ce/index.htm.

[5] AFC estimate based on Kim & Mao.

[6] AFC estimate based on Kim & Mao.

[7] Chen RY, Accortt NA, Westfall AO, et al. Distribution of health care expenditures for HIV-infected patients. *Clin Infect Dis.* 2006;42:1003–1010.

In short, the new system created under the 1115 waiver and delivery system transformation must preserve the best of the current system, while addressing its shortcomings. Such a system would certainly improve services for people with HIV and meet the Triple Aim. Our comments on the concept paper follow.

General Comments

We have several general comments on the waiver and possible consequences.

Capacity building funds to help organizations make the transition to billing for Medicaid services: To truly transform the health care system and meet the stated goals of the 1115 waiver to provide better coordination of care and cost-effectiveness, capacity building for organizations must include resources and training that prepare providers for Medicaid billing. For example, housing agencies that have never been able to bill for Medicaid services for supportive housing residents will need substantial assistance and time to prepare. Providers throughout the state are at differing levels of capacity and readiness for the changes in the delivery system. Indeed, providers will need technical assistance, training, and resources at deep levels to be able to connect with a medical network, improve their technology, collect data, or track outcomes and costs savings. AFC is willing to work with Illinois Medicaid to connect with different providers for additional information about their technical assistance and capacity-building needs. This will ensure that the 1115 waiver will most accurately reflect how the changing face of Illinois health care can benefit from the deep roots many providers have in their communities.

Costs Not Otherwise Matchable (CNOM): AFC strongly supports the goal of including CNOM as matchable services. Accordingly, we urge the state to propose that CNOM under the waiver include a broad variety of services, such as preventive services, food and nutrition services, and violence recovery services.

Protect the safety net during on-going systems transformations: Not all low-income individuals in the state will participate in the Medicaid program and there will be unmet needs throughout the state even after the transformation of the health care system. For example, historically marginalized people who are newly diagnosed as HIV-positive may be unwilling to enroll in a program like Medicaid, and as a result not link to HIV medical care and life-saving medical treatments. For the benefit of the community and these individuals, it will be important that the community services they are currently accessing remain available. While AFC urges that the broadest number of services be included as CNOM in the 1115 waiver application, we also ask that the state remain mindful that the 1115 waiver be constructed in such a way that recognizes that not all CNOM service dollars should be rolled over into the Medicaid program. For the foreseeable future, a portion of funds for safety-net services must remain available for people not enrolled in Medicaid in order to ensure that vulnerable Illinoisans can access necessary services and avoid future costs.

PATHWAY #1: HOME AND COMMUNITY BASED INFRASTRUCTURE, COORDINATION AND CHOICE

1A. Combine and Modernize HCBS Waivers.

Given state and national efforts to ensure continuity of care and better health outcomes for people with HIV, any effort to consolidate HCBS waiver services must offer people with HIV greater benefits than they are currently afforded. This necessitates a deliberate effort to ensure HIV expertise and culturally competent care is a driving requirement of system transformation activities affecting the HIV-positive HCBS waiver populations.

Background on the AIDS waiver: For the past two decades, the AIDS waiver has helped severely ill, low-income people with HIV successfully remain in their homes and in the community. It has a legacy of efficient operation, superior levels of cultural competency, and integration with other state and federally-funded programs. Today, the AIDS waiver assists nearly 1,000 severely ill individuals and prevents institutionalization with the delivery of essential AIDS-specialty community-based services. The average age of AIDS waiver clients is 52, and 70% are African American, 16% white, and 12% Latino. One-third are women, two-thirds male, and 1% transgender.[8]

The features that distinguish the AIDS waiver from other waivers are as follows:

- **Administration by a community-based agency:** The AIDS Foundation of Chicago has administered the AIDS waiver on behalf of the Department of Rehabilitative Services (DRS) since it was originally approved in the late 1980s. Sixty case managers are housed in 21 community-based organizations in the Chicago area (see attachment 1 for a complete list). Reflecting the integrated nature of the system, nearly all case managers are assigned part-time to manage AIDS waiver clients. Other HIV clients make up the rest of their caseloads. Case managers coordinate all facets of client services, including assessment and re-assessments, home visits, and services coordination include management of engagement and retention in medical care. AFC centrally bills and distributes payments on behalf of the delegate agencies, creating an efficient system for the network of partner entities and the state.

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- **Integration with other state- and federally-funded services:** AIDS waiver case managers are part of the Northeastern Illinois HIV/AIDS Case Management Cooperative (the Co-Op), an integrated network of organizations providing case management services under contract with AFC. AFC brings together 12 different funding streams to create a seamless case management and safety-net system. AFC's efforts coordinating multiple funding streams allow case managers to provide a seamless continuum of services to clients as they enter and exit eligibility for various programs. AFC's work coordinating various funder requirements serves to maximize scarce resources and shield clients

[8] Data from AIDS Foundation of Chicago, October 2013.

from unnecessary burden germane to the funding sources covering their care. As an example, because the AIDS waiver case management program is nested in the Co-Op, clients receive access to a full spectrum of Ryan White medical and social services they might not otherwise receive, such as emergency rent and utility assistance that keeps individuals from becoming homeless. This integration and specialization designed for people with a highly stigmatizing condition such as HIV must not be lost in HCBS waiver integration.

- **Ability to adapt over time:** In the early days of the AIDS waiver, when no effective treatments for HIV existed and infection meant near-certain death, services were designed to allow people to die with dignity in their own homes. Today, people with HIV are living longer, and the waiver has changed and adapted to fit the times. The AIDS waiver case management workforce is therefore increasingly assisting clients to strive toward care and treatment adherence, self management, and full independence. For many clients, their case manager is among the few individuals clients can talk to about their HIV infection and receive care, informed and compassionate care. Removal of this culturally competent care could dramatically undercut the benefits of the waiver as a modality for community wellness and independence from institutionalization.

The AIDS Foundation of Chicago urges the state to ensure that future system design builds upon successes to date in administering the AIDS waiver and offers vulnerable clients greater potential to improve their health and lives with greater access to expert HIV clinical and social service providers.

- **Maintain integration with Ryan White services:** Ryan White program services provide critical supports for people receiving AIDS waiver services that are available through no other programs. These include non-medical transportation, access to legal services, emergency rent and utility assistance to prevent homelessness.
- **Maintain cultural competency:** AIDS waiver program case managers are housed in agencies that are rooted in their communities. Many case managers are living with HIV themselves and have been born and raised in the neighborhoods where clients live. Furthermore, many are gay and lesbian, allowing them to build a greater rapport with the largely-gay client population.
- **Uphold standardization of training requirements:** Over its more than twenty-five years of existence, the Co-op has created a standard training curriculum for case managers. This ensures that if a client wishes to receive services from a different agency or moves to a new neighborhood, he or she will receive the same level of services from a new case manager who has the same core competencies. See attachment 2 for an agenda for the five-day training that all new AIDS waiver case managers must complete.
- **Protection of confidential HIV medical and personal information:** Illinois AIDS Confidentiality Act requirements are more stringent than those of the federal Health Insurance Portability and Accountability Act. Case managers, supervisors, and other agency staff need initial and refresher training on HIV-specific confidentiality.

- **Permanently assign clients to one case manager:** Clients are assigned to one case manager, who is responsible for meeting all their care-related, social service, and supportive service needs. This allows the client and case manager to build a strong relationship that promotes improved treatment compliance, resulting in lower medical costs.
- **Maintain a low client-to-case manager ratio:** The 30:1 ratio of clients to case managers in the AIDS waiver ensures that high quality services can be delivered as per of the needs involved in intensive case management. The low ratio allows case managers to better understand their client's needs, ultimately improving medical outcomes.
- **Focus on wellness, independence and viral suppression:** Because HIV today is both a chronic medical condition that is also communicable and incurable, a focus on maximum clinical benefit is critical for the patient as well as public health. Studies show that HIV-positive people who suppress HIV replication through medication adherence reduce biological risk of transmitting HIV by as much as 96%. Optimal outcomes in the AIDS waiver will therefore translate into lower Medicaid outlays in years to come. For these reasons, the AIDS Foundation of Chicago cautions against consolidation that would adversely affect the elements that have made the AIDS waiver a successful program for its vulnerable clients.

1C. Stable Living through Supportive Housing

- ISSUE: The AIDS Foundation of Chicago and its Center for Housing and Health coordinate over 700 units of supportive housing in partnership with 12 community-based providers. Clients include people with HIV, other chronic illnesses, mental illness, substance abuse conditions and chronic homelessness. Evidence-based data has shown that supportive housing for the homeless significantly reduces health care costs and improves health outcomes for these vulnerable populations. There is a shortage of supportive housing funding for both rent subsidies and supportive services to make this intervention most effective. Currently, AFC uses HUD funds for most of our intensive case management, as there are limited sources of funding for these services. However, these HUD dollars could be redirected towards rents if funding sources – such as Medicaid – were allowed to be used for case management services with the population. This would expand the pool of available supportive housing units and allow more high-need individuals to be housed, further lowering medical costs.
- RECOMMENDATION: We urge the 1115 waiver to include strong support for the creation of additional units of supportive housing with Medicaid funds. State-funded supportive housing should be made available to people with chronic physical illnesses as well as behavioral health challenges. The supportive housing dollars should not be limited for Williams and Colbert Consent Decree participants but also for the homeless and chronically ill populations, many of whom will end up in nursing homes if not supportively housed. Medicaid dollars should be made available directly or indirectly to organizations that do not bill Medicaid, such as supportive housing agencies that provide intensive case management services, because they significantly improve health outcomes and reduce costs. These organizations will need structured technical assistance to institute Medicaid billing systems.

- IMPACT: The research evidence is strong that supportive housing including intensive case management reduces Medicaid spending, especially unnecessary hospitalizations. Medicaid dollars should be used for supportive services and case management, which are essential parts of care coordination for homeless, chronically ill populations. Through increasing funding for supportive housing, the state can realize further cost reductions, improved population health outcomes, reduced public service costs and Medicaid spending.

PATHWAY #2: DELIVERY SYSTEM TRANSFORMATION

AFC strongly supports the state's work to transform the delivery system in ways that will directly improve health and wellness for people living with and affected by HIV. While it is clear that HIV is expensive to treat, there are significant untapped opportunities to improve outcomes for the HIV population and reduce costs. Very modest investments by new delivery systems in member outreach, provider education, information systems, partnerships with community-based providers, and quality monitoring significantly improve HIV care. Below, we outline the three challenges in HIV care and recommended interventions. Incentives should be structured to encourage plans and providers to adopt these interventions. The recommended improvements should be realized through language in contracts between the state and integrated delivery systems.

A. ISSUE: Many low-income people diagnosed with HIV are not successfully linked to HIV medical care, denying them the life-extending and cost-reducing benefits of early HIV treatment. In fact, a recent study shows that the Medicaid program nationally failed to meet even the most basic medical needs of people with HIV for HIV-specific care. The study demonstrated that just one in five people diagnosed with HIV while on Medicaid received HIV medical care within the first year after diagnoses, and just 26% received HIV care ever over the five-year period after diagnosis.[9]

This research demonstrated that newly diagnosed people with HIV were never successfully linked to HIV care. They were missing the benefits of early HIV treatment; when people with HIV get very sick – for example, because they drop out of HIV care – their medical costs can double from an estimated $13,885 per year for someone with HIV who is healthy to $36,352 per year for someone who has advanced HIV.[10] Furthermore, people receiving HIV treatment can significantly lower their risk of infecting other community members.

RECOMMENDATIONS:

- Health plans should require providers with electronic medical records to institute alerts that indicate when people diagnosed with HIV do not get medical care (e.g. miss appointments, do not present for care within a certain amount of time), and have procedures in place to actively follow up with the patient to engage them in care.

[9] Johnston S, Juday T, Seekins, D et al. *Patterns and Correlates of Linkage to Appropriate HIV Care after HIV Diagnosis in the US Medicaid Population.* Sexually Transmitted Diseases, 40:1 January 2013, p. 18-25.
[10] Chen *Clin Infect Dis.* 2006.

- Plans should reimburse providers for outreach and engagement to link newly diagnosed people with HIV to medical care, or have contracts with community-based organizations that can perform this essential role.
- Plans should explore performance-based contracting that rewards providers that exceed goals for linking newly-diagnosed people to medical care.
- Plans should reward providers that institute best practices for linkage to care, such as holding open access appointments for newly diagnosed people with HIV. Standards and expectations for successful linkage should be clear and involve evidence of appointment attendance.
- Plans should ensure that enrolled providers have strong linkages with Ryan White program services, including case management, to stabilize people with HIV.
- The state should institute HIV quality measures to hold plans and providers accountable for achieving high-quality, value-based care. A list of recommended HIV quality measures is included as attachment 3.

IMPACT: As a result of these changes, people with HIV will be linked to care as soon as they are diagnosed. Doing so will promote early intervention, delay the adverse outcomes associated with lack of treatment access, and also reduce new HIV infections in the community by providing medications that lower an individual's risk of transmission.

B. ISSUE: People with HIV who have low incomes drop out of medical care at very high rates, leading to immune system failure and costly hospitalizations. In the Chicago area and nationally, nearly one in five people with HIV have dropped out of medical care.[11] The reasons are complex and include factors such as behavioral health challenges, poverty, unstable housing, the stigma of HIV, and incarceration. In addition, people with HIV often need assistance and counseling to maintain adherence to HIV medications and prevent viral mutations that could cause someone to become resistant to HIV medications.

Most of the additional costs of care that arise from someone with an AIDS diagnosis are from hospital stays and medications to treat conditions associated with HIV.[12] Hospitalization costs are nearly six times higher and non-HIV medications eight times higher for someone with highly advanced HIV disease.

RECOMMENDATIONS:

- Health plans should institute comprehensive programs modeled after those piloted by HIV providers throughout the state to identify people who have dropped out of care and link them to supportive services to help them overcome barriers to care. Ideally, plans will not need to reinvent these successful programs, but can contract with community-based organizations or HIV health care providers who have developed outreach and retention expertise in this area. Community health workers are a key component of such interventions.

[11] AFC calculation based on CDPH 2010 data, as of 2012.
[12] Chen *Clin Infect Dis.* 2006.

- Plans should explore electronic alerts that notify providers and outreach teams when people with HIV do not pick up their medications or miss appointments.
- Medication adherence counseling – provided by a health professional or community health worker – should be made a reimbursable activity.
- Plans should institute systems that have the promise to increase adherence, such as text message reminders to take medications.
- Plans should have strong relationships, contracts, and data-sharing agreements with community-based agencies that provide HIV case management and access to supportive services funded by the Ryan White Program.

IMPACT: Helping people with HIV stay in care will allow people with HIV to maintain healthy immune systems, which will reduce hospitalizations and other costly interventions.

C. ISSUE: Community-based, responsive case management is needed to help people with HIV navigate systems of care. Health care reform offers unprecedented opportunities for low-income adults with HIV to access consistent, continuous health care in ways that can fundamentally change their lives and reduce the costs of care. Putting health insurance and health services within reach is necessary, but will not be in and of itself sufficient. People with HIV lack experience navigating the medical system and, due to chaotic life circumstances, poverty, substance use and mental health disorders, they often require additional support to address their challenges simultaneously and chart a new course to health and recovery.

AFC is the preeminent case management provider for low-income adults with HIV in the Chicago area. We are access and retention specialists, building bridges that engage people in much needed care, building motivation for long-term improvements in health status, and addressing the social determinants of health such as housing, employment and nutrition. We are also long-standing partners with government and health care providers in creating system design solutions for the public health, public safety and public finance challenges caused by untreated medical and behavioral health conditions. AFC coordinates the Co-op, which has a total of 150 case managers and 5,000 annual clients. The primary funding source for the system is the federal Ryan White Care Act, which provides services to low-income people with HIV.

RECOMMENDATION: AFC recommends the following:

- To incentivize integrated delivery systems to provide HIV-specific, culturally sensitive case management to people with HIV, HFS should institute a state plan amendment (SPA) as part of the system redesign to make targeted case management (TCM) a reimbursable service. Today, case management provided to people with HIV is not a Medicaid-reimbursable service.
- HFS should institute integrated delivery system contract requirements that stipulate that systems must provide case management services for people with HIV that meet specific requirements, including hours of HIV-specific training, access to services that will be funded only by the Ryan White Program (such as emergency rent and utility assistance, legal assistance, food and nutrition, and transportation to non-medical services),

low client-to-case manager ratios, and services geared toward the unique health needs of populations disproportionately affected by HIV/AIDS (gay and bisexual men, transgender women, people with histories of substance use, homeless or unstably housed populations, and those affected by the criminal justice system).

- Because the state and federal government has invested significantly in the development of culturally competent service infrastructure to advance HIV care and prevention strategies, system design must harness and modernize this infrastructure. Failure to do so will squander three decades of work and billions invested to evolve and improve the HIV/AIDS safety net, a grave consequences for tens of thousands of patients who rely on these systems of care.

IMPACT: Instituting a SPA for TCM would improve outcomes for people with HIV by incentivizing integrated delivery systems to invest in HIV case management. Ultimately, this would lower spending on health services for people with HIV and improve health outcomes.

PATHWAY #3: BUILD THE CAPACITY OF THE HEALTH CARE SYSTEM FOR POPULATION HEALTH MANAGEMENT

AFC strongly supports increasing the focus of health care providers and delivery systems on population health management. Helping a person with HIV stabilize their lives so they can get in care and reduce their viral load to the point where the risk of transmission nears zero may be a multi-year, intensive effort. Too often, health plans are focused on short-term cost-savings and are uninterested in an intervention that may save the taxpayer money. For example, preventing one new case of HIV can save at least $380,000 in lifetime medical care. Since someone might be a member of a plan for just one year, health plans are not incentivized to invest in interventions that will reduce HIV transmissions because the long-term benefit will accrue mainly to the state and taxpayer.

Our recommendations for specific problems and interventions follow.

ISSUE: High numbers of people with HIV are undiagnosed: An estimated 20% (1 in 5) of people with HIV are undiagnosed. Retrospective research shows that it is common for people later diagnosed with HIV to see providers multiple times before they are ever offered an HIV test.[13]

RECOMMENDATION: To identify people with undiagnosed HIV earlier, the U.S. Centers for Disease Control and Prevention (CDC) has recommended routine HIV testing since 2006.[14] The U.S. Preventive Services Task Force (USPSTF) recently gave routine HIV testing an A rating, which will require it to be covered by all health plans.

Examples of recommended interventions:

[13]Bernard M. Branson, MD, et al. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. U.S. Centers for Disease Control and Prevention, MMWR, September 22, 2006 / 55(RR14);1-17.

[14]Branson *MMWR* 2006.

- Plans should educate providers about the CDC recommendation and USPSTF rating.
- Plans should ensure all new members are screened for HIV.
- Plans should report to providers the number and rates of patients tested for HIV, and institute performance bonuses for achieving high rates of screening.

IMPACT: Diagnosing and treating an individual early is more than half the cost of treating someone late in the disease.[15] Moreover, individuals who are undiagnosed are more likely to transmit HIV to others in the community, since they are unaware of the need to take precautions against transmission.

ISSUE: Facilitate partnerships with community-based organizations for evidence-based STD prevention counseling. In 2008 the U.S. Preventive Services Task Force gave a B grade to behavioral counseling interventions delivered to individuals who have been diagnosed with an STD.[16] STD rates in Chicago and Illinois are extremely high. In fact, according to CDC, in 2011, Cook County had the highest number of gonorrhea cases and second-highest number of syphilis and chlamydia cases of any city or county.[17] Women ages 15-24 are the most impacted population, and STIs can have costly, life-long health consequences, including infertility and increased risk of HIV infection.

The USPSTF recommendation notes that STI behavioral interventions result lower rates of re-infection. The recommendation also noted that services need not be provided by licensed medical professionals. New federal regulations support released in 2013 (42 C.F.R. § 440.130 (c), effective Jan. 1, 2014) will allow such interventions to be delivered by non-licensed providers. The regulations define preventive services as: "services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to--(1) prevent disease, disability, and other health conditions or their progression; (2) Prolong life; and (3) Promote physical and mental health and efficiency." Prior to this new revision, preventive services were defined as those "provided by," rather than "recommended by."

RECOMMENDATION:

- Incentivize providers to increase STD screening of sexually active young women (National Quality Foundation measure 0033) by requiring public reporting of screening rates by provider.
- Allow non-licensed services providers, such as community-based organization staff, to bill Medicaid for STD counseling services when recommended by a licensed provider. In

[15] Chen *Clin Infect Dis.* 2006.

[16] USPSTF, "Behavioral counseling to prevent sexually transmitted infections." October 2008. Accessed 11/21/13from http://www.uspreventiveservicestaskforce.org/uspstf/uspsstds.htm. Note that USPSTF is currently updating this topic.

[17] Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2011. Atlanta: U.S. Department of Health and Human Services; 2012. Accessed 11/21/13 from http://www.cdc.gov/std/stats11/toc.htm.

addition, provide technical assistance to organizations to help them put billing systems in place.

IMPACT:

- Increasing behavioral counseling for people infected with STIs will reduce rates of STIs, reduce the costs associated with treating STIs, and lower the cost of treating women for conditions associated with STIs, such as ectopic pregnancy.

ISSUE: Identify Department of Public Health HIV and STD prevention services that are currently not Medicaid matchable and seek ways to obtain Medicaid funding for them. The Department of Public Health currently spends state dollars through the Illinois HIV lottery, the HIV lump sum state GRF appropriation, and other sources on HIV testing and related services, such as risk-reduction counseling. As part of the waiver, HFS and IDPH should explore ways to make some of these services billable through Medicaid. However, it is critical to recognize that for reasons of stigma and confidentiality, many people at risk of HIV may not want Medicaid or private insurance billed for an HIV or STD test. This is a particularly important concern for adolescents who may be on their parent's insurance.

PATHWAY #4: 21ST CENTURY HEALTH CARE WORKFORCE

AFC strongly supports efforts to professionalize community health workers and make community-based health activities reimbursable. Many of the activities described in these comments, such as outreach to individuals who have dropped out of medical care, could be performed by community health workers. The 1115 waiver should incentivize wider use of community health workers. In addition, the state should invest in a community health worker training, certification and continuing education program, perhaps in conjunction with the community college system, to allow wider training of community health workers.

Second, AFC urges the state to continue to invest in the HIV workforce. Many experienced HIV clinicians who started practicing 25 years ago are aging out of the field. AFC supports the workforce recommendations of the HIV Medicine Association, including increasing loan forgiveness for providers who work in agencies seeing high proportions of low-income patients, increased federal support for clinical training, and higher Medicaid reimbursement rates for HIV specialists.

As was previously mentioned, the redesigned Medicaid system must ensure that a robust, culturally competent HIV medical and social service workforce is in place to meet the needs of people with HIV.

CONCLUSION

The recommendations outlined in these comments present the opportunity to strengthen HIV care outcomes while reducing costs, helping to meet the Triple Aim. HIV remains a chronic yet communicable disease. While we have the technology and knowledge to prevent new HIV cases and improve health outcomes for people with HIV, it will require the political will to realize these goals.